b. The facility cost ceiling.

6. When an existing facility is leased, the facility costs per day will be limited to the lower of:

   a. Actual allowable facility costs, or

   b. for facilities owned or operated by the lessor for 10 years or longer, the applicable facility cost ceiling, or

   c. for facilities owned or operated by the lessor less than 10 years, 110% of the median of facility costs for all providers in the same category.

7. When a replaced facility re-enters the Medicaid program either under the same ownership as prior to the replacement or under different ownership, facility costs per day will be limited to the lower of

   a. Actual allowable facility costs or

   b. The median of facility costs for all other existing facilities which are in the same category.

VI. IMPUTED OCCUPANCY

In order to insure that the Medicaid program does not pay for costs associated with unnecessary beds as evidenced by under-utilization, allowable facility costs will be calculated by imputing a 90% occupancy rate. This provision will apply to:

1. Any new facility certified for participation in the Medicaid program on or after January 1, 1988.

2. Existing facilities, if the number of licensed or certified beds increases on or after January 1, 1988. In such cases, occupancy will be imputed for all beds.

3. Replacement facilities, certified for participation in the Medicaid program on or after January 1, 1988, if the replacement facility contains a higher number of licensed or certified beds than the facility being replaced.

4. Any replaced facility which re-enters the Medicaid program on or after January 1, 1988, either under the same ownership or different ownership.

5. Any closed facility which re-enters the Medicaid program on or after January 1, 1988.

Facility costs will be adjusted and the resulting rate change will become effective when any of the above occurs. Providers operating such facilities shall submit appropriate information regarding facility costs so that the rate adjustment can be computed.

VII. ADJUSTMENTS TO BASE YEAR COSTS

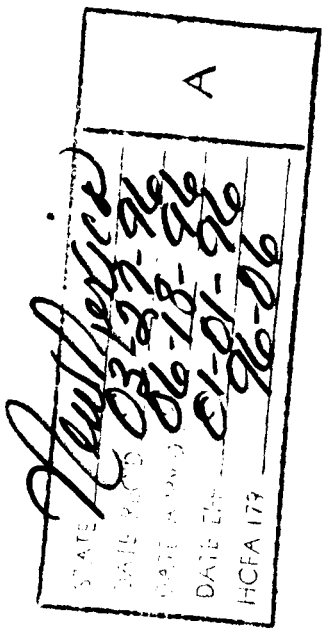
Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, social security taxation of 501(c)(3) corporations, minimum wage change, property tax increases, etc.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

Such additional costs must reach a minimum of $10,000 incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The Department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect: 1)beginning with the month the cost was actually incurred if prior approval was obtained, or 2)no later than 30 days from the date of the approval if retroactive approval was obtained.



At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the Department determines that a change in law or regulation has equal impact on all providers regardless of the ceiling limitation. An example of this would be the minimum wage law.

VIII. IMPLEMENTATION OF NURSING HOME REFORM REQUIREMENTS EFFECTIVE OCTOBER 1, 1990.

As mandated by Section 1919 of the Social Security Act, the following changes are made effective October 1, 1990:

A. Elimination of SNF/ICF Distinction

Effective October 1, 1990, the SNF and ICF distinctions will be eliminated and all participating providers will become NFs. In order to account for the change the following will be implemented:

1. Two levels of NF services will exist.

   High NF
   Low NF

2. A High NF rate and a Low NF rate will be established for each provider.

3. For existing SNFs, the High NF rate will be the provider's SNF rate in effect on September 30, 1990.

4. For existing ICFs, the Low NF rate will be the provider's ICF rate in effect on September 30, 1990.

5. For existing ICFs with no existing SNF rate, the High NF rate will be the provider's ICF rate in effect on September 30, 1990, plus an amount equal to the statewide mean differential (i.e. the average difference) of the operating component of current SNF/ICF rates.

6. For existing SNFs with no existing ICF rate, the Low NF rate will be the provider's SNF rate in effect on September 30, 1990, minus an amount equal to the statewide mean differential (i.e. the average difference) of the operating component of current SNF/ICF rates.

B. Cost Increases Related to Nursing Home Reform

To account for cost increases necessary to comply with the Nursing Home Reform provisions, the following amounts will be added to NF rates(see above), effective October 1, 1990:

High NF	$3.69
Low NF	$4.96

IX. PAYMENT OF RESERVE BED DAYS

When Medicaid payment is made to reserve a bed while the recipient is absent from the facility, the reserve bed day payment shall be in an amount equal to 50% of the regular payment rate.

X. RECONSIDERATION PROCEDURES FOR LONG TERM CARE DETERMINATIONS

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change in ownership) may request a reconsideration of the determination by addressing a Request for Reconsideration to:

Director
Medical Assistance Division
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

B. The filing of a Request for Reconsideration will not effect the imposition of the determination.

C. A request for Reconsideration, to be timely, must be filed with or received by the Medical Assistance Division Director no later than 30 days after the date of the determination notice to the provider.

D. The written Request for Reconsideration must identify each point on which it takes issue with the Audit Agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The Medical Assistance Division will submit copies of the request and supporting material to the Audit Agent. A copy of the transmittal letter to the Audit Agent will be sent to the provider. A written response from the Audit Agent must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the transmittal letter.

F. The Medical Assistance Division will submit copies of the Audit Agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the Audit Agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the Medical Assistance Division no later than 15 days after the date of the transmittal letter to the provider.

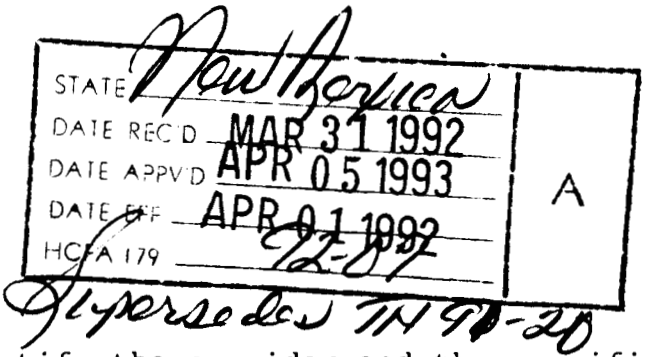
G. The Request for Reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the Medical Assistance Division Director to the Secretary, or his/her designee, within 5 days after the closing date for final submittals.

H. The Secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

I. The Secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The Secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The Secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

XI. PUBLIC DISCLOSURE OF COST REPORTS

A. Providers' cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the Medical Assistance Division. Information thus disclosed is limited to cost report documents required by Social Security Administration regulations and, in the case of a settled cost report, the notice of program settlement.



B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the Medical Assistance Division that its cost report has been requested, and by whom. The provider shall have 10 days in which to comment to the requester before the cost report is released.

D. The cost for copying will be charged to the requester.

XII. SEVERABILITY

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

Exhibit A

COMPARISON IN CERTIFICATION REQUIREMENTS

	Requirement	Cost Effect	Comments
1.	Nurse aide continuing education/inservice	$0.11	
2.	Supplies	$0.04	for continuing education and inservice
3.	RN-8hr.*	$0.39	
4.	24 hour nursing*	$0.18	
5.	Physician Involvement*	$0.06	
6.	Social services and elimination of ICF/SNF distinction*	$0.64	
7.	Wage adjustment for trained aides	$0.90	
8.	Overtime staff costs due to aide training	$0.23	
9.	PASAAR screen	$0.01	
10.	Pharmacy & dietary consulting	$0.15	
11.	Resident rights	$0.01	
12.	Interest bearing accounts/surety bonds	$0.10	
13.	Increased aide staffing for restraints and individualized needs	$1.11	

STATE New Jersey
DATE REC'D 03-31-93
DATE APPV'D 05-05-93
DATE EFF 04-01-93
HCFA 179 93-08

A

14. Increased social services/activities staff for individual resident needs	$0.72
15. Resident assessment	$0.31
TOTAL COST PER PATIENT DAY	$4.96

• Increases do not apply to existing SNFs as these requirements already built into SNF cost report.

STATE New Mexico
DATE REC'D 03-31-95
DATE APPV'D 05-05-95
DATE EFF 02-01-95
HCFA 179 95-08

A

SUPERSEDES: TN • 94-06

EXHIBIT B
ESTIMATION OF COSTS CBFA '87 L/C
NEW MEXICO

STATE New Mexico
DATE RECD 03-31-93
DATE APPVD 05-05-93
DATE EFF 07-01-92
HCFA 179 93-08

Page 1

A

SUPERSEDES: TN # 91-06

CATEGORY	COST PER PT. DAY	JUSTIFICATION
NURSE AIDE CONTINUING EDUCATION/INSERVICE	$.11	ASSUME A STANDARD OF 24 HOURS OF IN-SERVICE TRAINING PER AIDE THIS CATEGORY HAS TWO COMPONENTS: 1) THE COST OF MAINTAINING STAFFING LEVEL WHILE THE AIDES ARE RECEIVING IN-SERVICE TRAINING AND THE COST OF THE IN-SERVICE INSTRUCTOR. THE FIRST COMPONENT IS CALCULATED AS FOLLOWS: ADDITIONAL COSTS OF PROVIDING IN-SERVICE TRAINING TO AIDES NOT AT THE 24 HOUR LEVEL DIVIDED BY THE NUMBER OF PATIENT DAYS IN THOSE FACILITIES ($77151.25/$678796 = .0671) THE COST FOR THE IN-SERVICE INSTRUCTOR IS BASED ON THE SALARY LEVEL OF AN RN AND ON THE NUMBER OF HOURS NEEDED TO ACHIEVE THE STANDARD DIVIDED BY THE NUMBER OF PATIENT DAYS IN THE AFFECTED FACILITIES ($20166.33/$678796=.029)
SUPPLIES	$.04	THIS COST IS BASED ON THE PROVISION OF INSTRUCTOR MANUALS AT AN AVERAGE COST OF $22.13, VIDEOS AT AN AVERAGE COST OF $[illegible] PER FACILITY AND STUDENT STUDENT MANUALS AT AN AVERAGE COST OF $422.25 PER FACILITY. MISCELLANEOUS COSTS SUCH AS PAPER, PENS, ETC. ARE ALSO INCLUDED. A TURNOVER RATE IS CALCULATED FOR EACH FACILITY USING TOTAL W-2s MINUS CURRENT AIDE LEVEL. (661073/1375735) THE DIVISOR IS EQUAL TO RELEVANT PATIENT DAYS.
8 HRS PER DAY RN COVERAGE	$.39	THIS ADJUSTMENT ONLY APPLIES TO ICFs AND REPRESENTS THE COST OF OBTAINING THE REQUIRED COVERAGE. $536386/1375735, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS
24 HOUR NURSING COVERAGE	$.18	THIS IS ADJUSTMENT TO ASSURE LICENSED NURSE COVERAGE ROUND THE CLOCK. $249230/1375735
PHYSICIAN INVOLVEMENT	$.06	THIS ADJUSTMENT ONLY APPLIES TO ICFs AND REPRESENTS THE COST OF OBTAINING THE REQUIRED SERVICE. $97507/1375735, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS
SOCIAL SERVICES & ICF/SNF DISTINCTION	$.64	ADDITIONAL COSTS NECESSARY TO MEET NF STANDARDS, TO ASSESS NEW QUALIFICATIONS FOR SOCIAL WORKERS, ACTIVITIES DIRECTORS, MEDICAID RECORDS TECHNICIANS AND THE ADDITION OF A DENTAL ADVISOR. $882058/1375735, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS
WAGE ADJUSTMENT FOR TRAINED AIDES	$.90	THIS REPRESENT A DIFFERENTIAL BETWEEN NEW ENTRANCE WAGES AND TRAINED AIDES. $1241839/1375735
OVERTIME STAFF COSTS DUE TO AIDE TRAINING	$.23	THIS REPRESENTS THE COSTS OF ENSURING ADEQUATE STAFFING WHILE AIDES ARE IN TRAINING. $316963/1375735
PASARR SCREENING	$.01	THIS COVERS THE COST OF NEW AND ON-GOING LEVEL I SCREENS. $9129.21/1375735
RESIDENT ASSESSMENT AND CARE PLANNING/SERVICE	$.31	CALCULATED BASED ON FOUR ASSESSMENTS PER BED USING AN AVERAGE FACILITY SIZE OF 60 BEDS; AVERAGE OF 2 HOURS PER ASSESSMENT; AT A RATE OF $14.05 PER RN HOUR TO DO ASSESSMENT;

PHARMACY & DIETARY CONSULTANT	$.15	BASED ON 4 HOURS PER MONTH PER CONSULTANT AT $50 PER HOUR FOR 80 RESIDENTS. 2444/53018/32129
RESIDENT RIGHTS REQUIREMENTS	$.01	BASED ON $1.00 PER ADMISSION PACKET AT 15% TURNOVER RATE OF AVERAGE OF 80 RESIDENTS PER YEAR. INCLUDES COST OF FORMS, TAPES, TRANSLATION, ETC. 6132/32120
INTEREST BEARING ACCOUNTS SURETY BONDS	$.10	BASED ON THE NUMBER OF RESIDENTS REQUIRING THIS SERVICE. THIS ASSUMES 60 PERCENT OF THE RESIDENTS IN AN 80 BED FACILITY WILL NEED THE SERVICE; THE COST FOR THE ACCOUNTS IS ONE HOUR AT A COST OF $15 PER CLIENTS FOR 35 RESIDENTS; AND AN ADDITION OF $500 PER FACILITY FOR THE SURETY BONDS.
ACTIVITIES/SOCIAL SERVICES INCREASED STAFF FOR INDIVIDUALIZED SERVICES	$.72	ADDITIONAL STAFF TO ADDRESS RESIDENT NEEDS. BASED ON 30 HOURS OF SOCIAL SERVICES AND 10 HOURS OF ACTIVITIES WITH ASSOCIATED TOTAL COSTS OF $19,500 AND $6750 RESPECTIVELY PER 80 RESIDENTS.
INCREASED AIDE STAFFING FOR INDIVIDUALIZED SERVICES	$1.11	BASED ON 2 FTE AIDES WITH BENEFITS PER DAY. ASSURE AIDE COST OF $6.12 PER HOUR WITH BENEFITS AT 16 HOURS PER DAY FOR 80 RESIDENTS.
TOTAL OBRA '87 LTC COST PER PATIENT DAY	$4.96	

NOTE:
ESTIMATES FOR THE FIRST NINE ITEMS IN THIS DOCUMENT WERE DERIVED FROM FACILITY SPECIFIC INFORMATION COLLECTED VIA A COPYRIGHTED TOOL DEVELOPED BY THE NEW MEXICO HEALTH CARE ASSOCIATION, PIERSON HALL & BOWN & BDC SEIDMAN. THE REMAINING ITEMS WERE DEVELOPED BY THE BY A REIMBURSEMENT COMMITTEE OF THE NMHCA.
THE NMHCA THEN PRESENTED A PACKAGE TO THE MEDICAL ASSISTANCE DIVISION THE DIVISION REVIEWED THE SUBMISSION THEN RECOMMENDED ADDITIONAL CHANGES.
THESE FINAL FIGURES REPRESENT THE FINAL NEGOTIATIONS WITH THE EXECUTIVE DIRECTOR AND PRESIDENT OF THE ASSOCIATION.

STATE	New Mexico
DATE REC'D	03-31-95
DATE APPV'D	05-05-95
DATE EFF	02-01-95
HCFA ITN	95-08
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SUPERSEDES: TN • 94-26